

## Patient History

Name: \_\_\_\_\_ M  F  Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Weight: \_\_\_\_\_ Goal Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(w/o shoes)  
Home phone: \_\_\_\_\_ AM  PM  Work phone: \_\_\_\_\_ AM  PM   
Email Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Is this the current Email Address?  Yes  No If No, the current Email Address: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Clinic: \_\_\_\_\_ Insurance \_\_\_\_\_

A history of your present and past health problems is a very important part of your examination and treatment. Please answer the following questions carefully and completely. The information in this history is kept strictly confidential.

### PRESENT ILLNESS:

1. At what age did you begin to gain excess weight: \_\_\_\_\_ What was your highest non-pregnant weight at age 20 as an adult \_\_\_\_\_, and 1 year ago \_\_\_\_\_?
2. What condition, situation, factors and/or behavior (e.g. pregnancy, stress induced eating, night time snacking, etc.) contributed to your weight gain? \_\_\_\_\_
3. What is the main reason for your decision to lose weight? \_\_\_\_\_

4. If you lose weight, but then regained, please indicate the most important reasons for the weight gain:

**(1=most important, 2=moderately important, 3=least important)**

_____ less exercise	_____ lack of support/diet sabotage	_____ overeating at meals
_____ infrequent clinic visits	_____ stopped weight checks at home	_____ overeating between meals
_____ compulsive craving	_____ lack of planning ahead	_____ ate out often/socializing
_____ stress	_____ not keeping a food diary	_____ depression

5. List previous diets you have tried (include dates and results of weight loss) \_\_\_\_\_
6. Do you feel out of control while eating? Yes  No  If so, which food? \_\_\_\_\_  
 Inactive - no regular physical activity
7. Activity level: (pick only one)  
 Light activity - usually during leisure time  
 Moderate activity - occasional activity such as weekend golf/tennis/jogging/cycling/swimming  
 Heavy activity - consisting of lifting, stair climbing or active sports 3 times per week  
 Vigorous activity - consisting of extensive exercise for 60 minutes at least 4 times per week

8. List any medications w/dosage you have used in the **past** or are **currently** using for weight loss/control (include over the counter): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

9. List all prescribed medications & dosage you are currently taking (including birth control, herbal remedies & vitamins):

10. List medication & food allergies: \_\_\_\_\_

11. Have you had a heart attack; stroke; other serious illness; or have been hospitalized in the last 6 months? If yes, please explain

12. List all surgeries including cosmetic \_\_\_\_\_

13. Have you had Bariatric Surgery(Gastric Bypass or LAP Band Surgery) for weight control? If yes, please provide month and year.

14. Do **you** or a **family member** currently have a problem or have ever had a problem with any of the following: \_\_\_\_\_ month \_\_\_\_\_ year

Problem	SELF	FAMILY	Describe/Comments	Problem	SELF	FAMILY	Describe/Comments
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol use/abuse	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis A,B or C	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS or HV	<input type="checkbox"/>	<input type="checkbox"/>		High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Back/joint pain	<input type="checkbox"/>	<input type="checkbox"/>		High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Binge/purge or Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>		Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Insomnia (or sleep apnea)	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pains (Angina)	<input type="checkbox"/>	<input type="checkbox"/>		Kidney trouble or disease	<input type="checkbox"/>	<input type="checkbox"/>	
Colitis	<input type="checkbox"/>	<input type="checkbox"/>		Leg/foot trouble or Gout	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		Seizure disorder or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		Skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Drug use/abuse	<input type="checkbox"/>	<input type="checkbox"/>		Smoking	<input type="checkbox"/>	<input type="checkbox"/>	# Of Cigs/Packs/day
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Gall stones	<input type="checkbox"/>	<input type="checkbox"/>		Swelling of hands and/or feet	<input type="checkbox"/>	<input type="checkbox"/>	
Gastric/stomach Disorder (ulcers)	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	

15. List all medical and/or psychological or psychiatric conditions (including depression & anxiety) you have been treated for, or are currently being treated for \_\_\_\_\_

16. Who will be your support system during weight loss? \_\_\_\_\_

Family physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

M.D./N.P. Signature: \_\_\_\_\_

## Lindora Patient Data Demographics

- 1) Name: \_\_\_\_\_
- 2) Address: \_\_\_\_\_
- 3) Gender:
- Male
- Female
- 4) Date of Birth: \_\_\_\_\_
- 5) Ethnic Background:
- African American
- Mexican American
- Other Hispanic
- Asian
- Caucasian
- Other \_\_\_\_\_
- 6) Marital Status:
- Single
- Married
- Divorced
- Separated
- Widowed
- 7) Approximate Annual Household Income:
- Under \$30,000
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 - \$74,999
- \$75,000 - \$99,999
- \$100,000 and over
- 8) Highest level of education achieved:
- Finished grade school
- Graduated high school
- Finished 2 years of college
- Graduated college
- Graduated professional school  
(MD; DDS; JD; PhD; MS; RN, etc.)
- 9) Other family members that are overweight or obese:
- Mother
- Father
- Spouse/Partner
- Brother(s) and/or Sister(s)
- Grandparents
- 10) At what age did you begin to gain excess weight:
- 0 -10 yrs.
- 11 -16 yrs.
- 17 -25 yrs.
- 26 -35 yrs.
- After 35 yrs. of age
- 11) Do you have a history of and/or a current problem with compulsive eating; bingeing; or an eating disorder (binge/purge behavior, excessive use of laxatives/diuretics)?
- Past history not resolved
- Present problems for more than 2 years
- Present problems for less than 2 years
- No past or present history
- 12) How much do you smoke?
- I never smoked
- Less than a pack a day
- More than a pack a day
- More than 2 packs a day
- I quit smoking

- 13) How much alcohol do you presently drink on average per week?
- I never drink
  - 0 - 2 drinks
  - 3 - 5 drinks
  - 6 - 10 drinks
  - More than 10 drinks
- 14) In your family is there a history of, and/or have you ever been a victim of:
- Alcoholism
  - Drug addiction/substance abuse
  - Sexual abuse
  - Physical abuse/violence
  - Emotional abuse/violence
- 15) Do you use food and eating as a way of dealing with stress, anxiety or depression?
- No
  - Occasionally
  - Frequently
  - Very frequently
  - All the time
- 16) I have the following diseases:
- High Blood Pressure
  - High Cholesterol
  - High Triglycerides
  - Heart Disease
  - Diabetes Mellitus
  - Osteoarthritis or Back Pain
  - Gallbladder Disease/Gall Stones
- 17) I take medication for the following diseases:
- High Blood Pressure
  - High Cholesterol
  - High Triglycerides
  - Heart Disease
  - Diabetes Mellitus
  - Osteoarthritis or Back Pain
  - Gallbladder Disease/Gall Stones
- 18) Why do you think you have a weight problem?  
Check all that apply to you
- Eating the wrong kinds of foods
  - Eating too much food
  - Too much nibbling, snacking, and/or late night eating
  - Overwhelmed with life's problems and stress
  - An internal metabolic or medical problem
  - Not enough exercise
  - I don't know
- 19) I exercise for at least 10 minutes or more:
- Never
  - Once a week
  - 2 - 3 times a week
  - 4 - 5 times a week
  - more than 6 times a week
- 20) My present weight is \_\_\_\_\_ lbs.
- 21) My highest weight ever was \_\_\_\_\_ lbs.
- 22) The number of different diets and/or different diet programs that I have tried before coming to Lindora is:
- 0
  - 1 - 3
  - 4 - 6
  - 7 - 10
  - more than 10

This information will help us to serve you better. It will remain confidential.  
Thank you for your time!

Name \_\_\_\_\_

Clinic \_\_\_\_\_

Date \_\_\_\_\_

## Disclaimer

The CD, Relaxation/Guided Visualization, has been psycho acoustically designed to create an audio environment for mental relaxation. The techniques used on this CD are the most powerful ones available to induce a state of deep relaxation. To our knowledge we personally know of no case of or have any knowledge of any case on record where an individual has ever been harmed in any way by using the techniques on this CD. However, because of its powerful effect, it is necessary as a general practice to have each person that is issued this CD to sign the following disclaimer.

In consideration of my acceptance as a participant in this CD program, I have a full understanding that this CD has been created for deep relaxation and guided visualization. By signing this disclaimer I agree to **never** listen to this CD or allow any other individual to listen to this CD while operating a motor vehicle or any other dangerous equipment. I assume full responsibility for the use of this CD.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_